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Published Online May 15, 2020 https://doi.org/10.1016/S0140-6736(20)31145-4

Steam inhalation and paediatric burns during the COVID-19 pandemic

Published Online May 15, 2020 https://doi.org/10.1016/S0140-6736(20)31144-2

Steam inhalation is traditionally used as a home remedy for common colds and upper respiratory tract infections. The evidence base of the practice is weak, with unproven theories that the steam loosens mucus, opens nasal passages, and reduces mucosal inflammation, or that the heat inhibits replication of viruses.[1,2]

Scald injuries are the commonest cause of burns in children. Every day, more than 100 children present to the emergency department with burn injuries in the UK.[3] Since lockdown measures were implemented last month, our Burns Centre at Birmingham Children's Hospital, Birmingham, UK, received a 30-fold increase in the number of scalds directly resulting from steam inhalation. The mechanism is most frequently accidental spillage of boiling water from a bowl or from a kettle. Children have occasionally been left unsupervised.

On average, our unit admits two patients per year with scalds related to steam inhalation. Over the past month alone, we have admitted six children with burn injuries due to this mechanism, with the youngest child aged 2 weeks, and the most severe case involving 8% of the child's total body surface area, requiring excision and skin grafting.

We surveyed Burns Services across England. With an 86% response rate, we found that 50% of centres have had an increase in scalds relating to steam inhalation. This correlated with regions of England with higher prevalence of COVID-19 (London and South East; West Midlands; North West). Two thirds of centres reported an association with Asian ethnicity (Indian, Pakistani, Bangladeshi, or Other).

The common misconception is that steam inhalation is beneficial in preventing and treating respiratory tract symptoms. Social media and home-made tutorials from unverified sources have a role in misleading parents into practising this dangerous habit.

Studies have shown that there is no additional symptomatic relief from the use of steam inhalation therapy to treat the common cold.[1,4] However, a survey of general practitioners in 2016 showed that 80% of general practitioners have recommended steam inhalation as a home remedy to their patients.[5]

Steam inhalation is a hazard to children. Resulting scalds can ultimately lead to hospital admission, surgery, and life-long disfigurement. Parental education is paramount to preventing these injuries. Clinicians should actively discourage steam inhalation and educate parents about alternative treatments for their child.

We declare no competing interests. We thank our colleagues throughout the Burns Network in England and Wales for their collaboration towards this Correspondence.

*Colin T Brewster, Jia Choong, Clare Thomas, David Wilson, Naiem Moiemen
colin.brewster@nhs.net

Birmingham Children's Hospital, Birmingham Women's and Children's NHS Foundation Trust, Birmingham, UK

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Health inequity during the COVID-19 pandemic: a cry for ethical global leadership

Widespread reports of disproportionate impact of the COVID-19 pandemic among already vulnerable communities worldwide, from New York City to New Orleans and Chicago, to the shocking pictures of bodies lying in the streets in Ecuador, represent a prelude of the impact in low-income and middle-income countries, home to more than 80% of the world's population. Disadvantaged people are at higher risk of infection and death from COVID-19, and they have less access to care due to systems that treat health as a commodity and not a human right. Furthermore, most health-care systems are not prepared to handle a pandemic of this magnitude. Overwhelmed European and US systems are ominous reminders of the challenges faced in poor countries.

Despite widespread acts of solidarity, we are witnessing unconscionable stockpiling by wealthy countries and attempts by many to extract profits from the crisis. Hoarding and speculation should be condemned in the strongest terms and measures taken globally to ensure equitable access for countries with fewer resources.

On April 21, 2020, we submitted an open letter to the UN calling for ethical global leadership to mitigate the unfair additional health and socioeconomic burden of this pandemic on disadvantaged populations. We proposed to create a multisector Global Health Equity Task Force, housed within WHO, charged with taking necessary steps for a comprehensive, equity-focused response. This Task Force would develop strategies for fair allocation of resources; including legislation to trigger coordinated production of and access to quality generic diagnostics, medicines, vaccines, supplies, and equipment, abolishing any pandemic-related patents. It would also support the development of enhanced recommendations on preparedness and response for our most vulnerable populations, and tailored, secure de-confinement strategies. Additionally, it would promote steps to strengthen universal health-care systems globally and to address the economic disparities that have led to this appalling inequity.

The open letter to the UN has been cosigned by more than 120 diverse entities, representing more than 5 million public health practitioners, scientists, academics, health-care professionals, and advocates, including the World Federation of Public Health Associations, Latin American Alliance for Global Health, InterAcademy Partnership, World Federation of Critical Care Nurses, and American Academy of Pediatrics. The letter has also been endorsed by former heads of state and ministers, as well as an array of advocates for the right to health from more than 50 countries and a wide spectrum of cultures, contexts, and ideologies, echoing the plea for an equitable response to the pandemic.

We declare no competing interests. DC is Former Minister of Health of Ecuador and former pro tempore president of the Council of Health Ministers of South America. PB is a full member of the Brazilian National Academy of Medicine. RSM is president of the Latin American Alliance for Global Health and former Minister of Health of Costa Rica. LCR is president of the World Federation of Public Health Associations.

*David Chiriboga, Juan Garay, Paulo Buss, Rocío Sáenz Madrigal, Laetitia Charmaine Rispel
david.chiriboga@umassmed.edu

University of Massachusetts Medical School, Worcester, MA 01655, USA (DC); National School of Public Health of Spain, Madrid, Spain (JG); The Oswaldo Cruz Foundation, Rio de Janeiro, Brazil (PB); University of Costa Rica School of Public Health, San José, Costa Rica (RSM); and Witwatersrand University School of Public Health, Johannesburg, South Africa (LCR)

Time for global health diplomacy

2019 was *The Lancet's* Year for Nutrition. Highlights included reports from the EAT-*Lancet* Commission[1] and The Global Syndemic Commission,[2] both emphasising that global trade systems must be transformed to ensure healthy and sustainable diets. But what developments can be expected following these reports? We might get an indication by considering what has happened since *The Lancet's* 2009 Trade and Health Series. This Series criticised the trade agreements of the World Trade Organization (WTO) for being detrimental to global health, among other things, by facilitating unhealthy diets.[3] So where are we now, more than a decade after the Trade and Health Series?

For the **Trade and Health Series** see https://www.thelancet.com/series/trade-and-health

Overall, the development has been negative. Trade agreements still facilitate unhealthy lifestyles.[4] Three-quarters of the world's population live in middle-income countries, where death rates due to dietary risk factors have increased (figure). By contrast, high-income countries have reduced death and disease rates due to dietary risk factors (figure), suggesting that much of this suffering is preventable. We must learn from previous implementation failures and act to ensure that the Year for Nutrition is followed by a fundamentally different development.

Historically, the health community has failed to place the issue of health on the agenda of the WTO,[5] even though the rapid increase in lifestyle-related diseases in middle-income countries indicates that stricter trade regulations would benefit the health of billions. To counterbalance the immense influence of profit-seeking transnational corporations, physicians—the uncontested authorities on health issues—must get more involved in

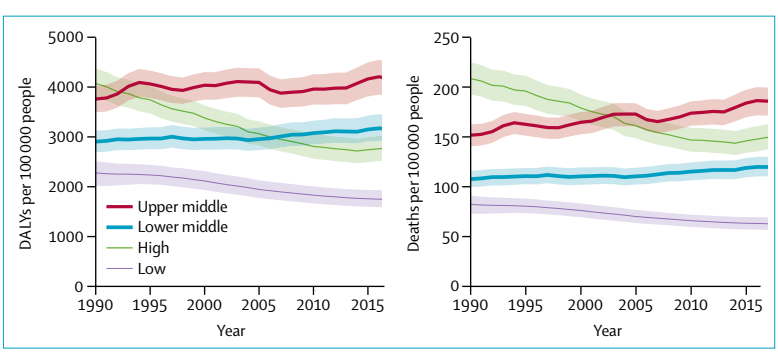

Figure: **Disease burden over time due to dietary risks**
For an individual, a DALY of 1 indicates death, whereas a DALY of 0 indicates perfect health. Income groups are as defined by the World Bank. Line width is proportional to 2017 population size in each income group (low income countries=0·7 billion; lower middle income countries=3·1 billion; upper middle income countries=2·6 billion; high income countries=1·2 billion). Data from Global Burden of Disease results tool. DALY=disability-adjusted life-year.

For the **Global Burden of Disease results tool** see http://ghdx.healthdata.org/gbd-results-tool